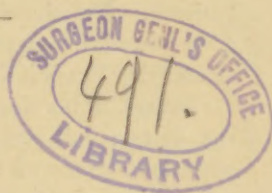


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RECTAL ULCERS AS A COMPLICATION OF
PARAMETRITIS POSTERIOR.*

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I BRING to you for your consideration this evening a question which has been of very considerable interest to me for many months past, and which, though a minor point in the pathology and symptomatology of pelvic diseases, may prove of assistance to us in our treatment of this disorder and the relief of the pain resulting therefrom.

The great majority of those who come to us for help do so because they have *pain*; and if we relieve this more or less completely, restore them once again to their old condition of health and strength, we shall find them contented and happy, little heeding the pathological remnants of which we alone are cognizant.

In the department of gynæcology, I believe I may safely say that those patients suffering from chronic inflammation of the pelvic connective tissue are by far the most unsatisfactory and the greatest tax upon our ingenuity and

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patience. Prominently among these are those suffering from posterior parametritis, or inflammation of the cellular tissue lying beneath the folds of Douglas.

Savage, in his clear description of the subperitoneal tissue, writes: "A plane extending from the middle of the posterior surface of the symphysis pubis to the point of articulation of the *third* with the *fourth* sacral vertebra, which intersects the uterus at the junction of the body with the neck, will, with rare exceptions, divide the pelvic cavity into two spaces—a peritoneal and subperitoneal. The parts lying below this plane are imbedded in the cellular tissue which occupies that portion of the pelvis which contains *no* intestine. The structure consists of fibro-elastic, muscular, and connective-tissue elements, and is so arranged that its meshes or cells communicate freely with each other."

On carrying our examination further, we shall find that from the posterior surface of the uterus, a little above the junction of the cervix with that organ, the muscular bands of the folds of Douglas, surrounded by this same cellular and loose connective tissue, pass to the lateral parts of the sacrum, nearly at the level of the *second* vertebra. The upper so-called posterior insertion of these muscular bands varies considerably, though it would seem that they always loose themselves in the muscular walls of the rectum and subserous connective tissue. The anterior or lower insertion is formed by some muscular fibers from each side coalescing behind the uterus and forming a single unique muscle, called by Luschka the *musculus retractor uteri*.

Thus it would seem that where exudation into the meshes of the cellular tissue has taken place, and where the pathological condition has persisted sufficiently long, the perirectal tissues must frequently be involved.

The pathological process in this locality varies little

from that found elsewhere in the body. In cases where the poison is not sufficiently virulent to cause suppuration, there must be extensive exudation of albuminous or fibrinous material in the meshes of the cellular tissue, as shown by soft swellings that can be observed shortly after the beginning of the process. Where the case is recent, the connective tissue is largely infiltrated with gelatinous material containing numerous small cells. In the subsequent chronic condition the soft swellings become dense, the fluid portion having been absorbed, and out of the cellular tissue is formed circumscribed hard tumors poorly supplied with blood, often reaching to the inlet of the pelvis, insinuating themselves between the folds of Douglas, to the rectum or even becoming prolonged beyond the limits of the true pelvis. The ultimate cicatricial contraction and hardening is readily found with the microscope.

Schultze is of the opinion that parametritis posterior is generally either confined to one side or much more extensive on one side than on the other, preferably the left—viz., the rectal side.

Ætiology.—We may roughly divide our patients into three classes:

1. Virgins.
2. Nulliparæ.
3. Parous women.

Among virgins, the most constant pathological factor is chronic pelvic congestion due to constipation. Secondly, traumatism followed by infection, such as wounds caused by the introduction and wearing of pessaries, gynæcological manipulations, and finally specific vaginitis due to infection from dirty fingers, cloths, sponges, etc.

In regard to the other two classes, Schultze conclusively states that the causes of parametritis posterior, though pretty often of puerperal origin, are, it must be stated, far more

frequently not so. The occurrence of puerperal parametritis posterior is very commonly due to infection after laceration of the perinæum, or even after some trivial injury to the posterior wall of the vagina. The exudation is by no means always considerable, the acute stage is often very short, and the local phenomena very slight. The febricula of puerperal women, the single rise in temperature formerly spoken of (milk fever), is often nothing but parametritis posterior.

In unmarried women and in those who have never been confined, parametritis posterior is generally subacute or chronic from its commencement. Mechanical injury, repeated straining of the folds of Douglas by the passage of large masses of fæces in habitual constipation, perhaps even infection from fissures of the rectum, and extension of the processes of endometritis to the parametrium, especially as a result of the stagnation of the catarrhal secretion, appear to be the principal causes of parametritis posterior chronic from its commencement in persons of the class just mentioned, while acute non-puerperal parametritis, in the majority of cases, is either traumatic or depends upon infection which is not infrequently gonorrhœal.

In a large number of cases this pathological process, exudation, hardening, and contraction is not limited to the immediate neighborhood of the uterus, but is concentrated at the posterior or rectal attachment of the ligament, and contraction in this locality means direct injury to the rectal and perirectal tissues.

At this level—viz., that of the first and second sacral vertebræ—the great venous plexus of the rectum has become so concentrated that we have left only the superior hæmorrhoidal vein or its immediate tributaries in which any obstruction to the onward flow of blood results in an over-distention or varicose condition of the distal veins. The

morbid tissue changes hitherto described, by their interference with the return circulation, doubtless cause a marked stagnation in and dilatation of the rectal plexus, ultimately producing a condition analogous to that found in the lower extremity.

When to this is added the evil effects of habitual constipation, irritation, abrasion, and septic absorption from the passage of large and very frequently hardened masses of fæces, the ultimate development of a varicose ulcer would seem a very natural result.

These ulcers are situated most frequently on the posterior rectal wall, from an inch to an inch and a half above the sphincter; in a general way, I should say that they occur half as often on the anterior wall.

They vary in size from that of a dime to a twenty-five-cent piece and are frequently multiple. On examination with the speculum, a smooth basement of granulation tissue with a well-defined margin is shown. The surrounding mucous membrane is decidedly hyperæmic, and at times covered with a thin coating of mucus. So far as I have been able to determine, they invariably lie in the lowest portion of the rectum, but a short distance above the sphincter ani—a locality where, owing to muscular action and impaction, traumatism would be more prone to occur. The examination is almost invariably accompanied by pain and hæmorrhage.

Symptoms.—Let me quote a case from Mathews's *Treatise on Diseases of the Rectum, Anus, and Sigmoid Flexure*,* just published :

“A lady, aged twenty-four, married, was referred to me by a gynæcologist. She had complained for many months with backache, pain down the thighs, general lassitude, melancholia,

* D. Appleton & Co., New York.

a bearing-down sensation in both vagina and rectum, pain over the seat of both ovaries, constipated habit, leucorrhœa, loss of flesh, irregular menstruation, difficult micturition, and a slight discharge of mucus from the bowel. Upon an examination of the womb and its appendages by the gynæcologist, there had not been enough trouble found to account for her symptoms. He treated her for several months, however, and, her case not clearing up, he advised her to consult me. Upon examining the rectum with a speculum, I found it highly congested, very red, and sensitive, and a film of mucus covered the entire circumference of the gut for several inches up. The cause for this extensive congestion was not discernible. I was satisfied, however, that all the symptoms mentioned were purely reflex from the rectum, and proceeded to treat her. . . . The redness of the mucous membrane and all pain gradually disappeared; the discharge ceased and all reflex trouble vanished."

I give you this, not from my own gynæcological case books, but from a treatise on rectal surgery. This patient had no rectal ulcers, probably because the obstruction above was not sufficiently complete; but there is little doubt in my mind that a more careful examination would have shown a parametritis posterior. The cure of the rectal condition alone was sufficient to cause a disappearance of her pelvic symptoms. With the addition of ulceration the suffering would have been more acute.

It is a notable fact that ulceration, very extensive in character, may exist in the rectum located above the sphincter muscles and cause very little (rectal) disturbance, or at least the disturbance is out of all proportion in its insignificance to the extent of the ulceration. It is only where the external sphincter muscle is involved in the disease that we have the great distress following.

We have, then, a class of patients suffering from pain located in the ovarian and lumbar region, headache, general depression, etc. Not always is there a distinct history of

habitual constipation, and even less frequent are complaints of rectal disease. On examination, we find the parts fairly normal with the exception of chronic metritis and parametritis posterior, as shown by fixation and hardening of the uterus, thickening and tenderness of the folds of Douglas; the physical signs not at all commensurate with the complaints of the patient. Place them in Sims's position, and, on rectal examination, we shall frequently find the source of the reflex irritation—viz., rectal ulcer.

The treatment is simply a combination of the established routine, respectively, for the two conditions; for the uterine and para-uterine the use of mild counter-irritation, depletion by means of hydragogue tampons and massage—all directed toward the relief of pelvic congestion, the softening and absorption of the inflammatory exudate.

For the rectum, dilatation so far as is possible in ambulatory cases; where practicable, divulsion of the sphincter under ether with subsequent rest in bed. The treatment of the ulcer is tedious, nevertheless it is gratifying to note the rapid improvement, often apparently out of proportion to the change in the rectal condition. Having thoroughly irrigated the rectum and washed the ulcer with a solution of bichloride of mercury (1-to-1,000), I have found nothing better than the strong solutions of nitrate of silver—from forty grains to a drachm to the ounce. The pure stick and other stronger cauterants have, in my experience, not proved so serviceable. The ulcer and mucous membrane is well dusted with iodoform. Following each defecation the patient is instructed to wash out the bowel with warm water and afterward with a saturated solution of boric acid. It would seem hardly necessary to say that careful attention is paid to the action of the bowels. So far as I have gone—and my cases are now quite numerous—my results have been very gratifying.

Briefly summarized, the points which I have endeavored to bring to your attention this evening are :

1. That para-uterine cellulitis posterior, by its hardening and subsequent contraction, obstructs the return flow of blood from the rectum, producing stasis in and a varicose condition of the rectal plexus.

2. By the irritation and abrasion of the mucous membrane, ulceration follows.

3. In a large number of cases the symptoms resulting therefrom are reflex and referred to the genital system primarily the region of the ovaries.

4. Treatment of the parametritis in most cases is not completely successful unless careful attention is directed to the rectum, whereby the reflex and most troublesome symptoms are relieved.

It has been my desire this evening to gather together these little odds and ends of the past two years, and to put them into some tangible form suitable for your consideration.

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